

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 832

CERTIFICATE OF DEATH

Reg. Dist. No. 999

1. PLACE OF DEATH:

County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 week
Hospital, institution, or street address where death occurred:
415 Davis St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Ms County Talbot
City or town Offord
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1
(If rural, give LOCATION)
2. (a) If veteran, name war

3. (a) FULL NAME

Percy Bayne

3. (b) Social Security Number

4. Sex M. 5. Color or race W. 6. (a) Single, married, widowed, or divorced Widowed

8. (b) Name of husband or wife Mary E. Bayne

7. Birth date of deceased (mo., day, yr.) 1870 6. (c) If alive, give age years

8. AGE: Years 77 Months 7 Days 7 If less than one day .hrs. min.

9. Birthplace Offord, Talbot, Md.
(Town, county, and state)

10. Usual occupation Retired

11. Industry or business

12. Name Wm H. Bayne

13. Birthplace Md.

14. Maiden name Annie Douglas

15. Birthplace Md.

16. Informant Mrs. Anna M. Smith

Address H. Washington St. Eastern Md.

17. (Burial, cremation, or removal, Which?) Burial Date thereof March 23, 1947
(month) (day) (year)

Cemetary or crematory Offord

Location Offord, Md.

18. Funeral director The Hill's Johnson Co

Address Salisbury, Md.

19. 3/23, 19 47 Registrar H. Hill Johnson

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 21, 1947 at Ms

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3/20 19 47, to 3/21 19 47
and that I last saw him alive on 3/20 19 47

Immediate cause of death Coronary Heart Disease sudden

Due to Acute

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Oliver J. Fisher

M. D. or other

Address Salisbury, Md. Date signed 3/21/47

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 12 1947

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 3330

1. PLACE OF DEATH:

County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

8 years
Hospital, institution, or street address where death occurred:

John B. Parson Home

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Wicomico

City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)

Street No. John B. Parson Home
(If rural, give LOCATION)

2.(a) ☒ Veteran, name war

3. (a) FULL NAME

Addie Benson

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widow

6.(b) Name of husband or wife William H. Benson

7. Birth date of deceased (mo., day, year) Aug. 2nd 1868 7.(c) If alive, give age Dead years

8. AGE: Years 78 Months 7 Days 14 If less than one day hrs. min.

9. Birthplace near Laurel Delaware
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name William S. Moore

13. Birthplace Seaford Delaware

14. Maiden name Elija G. Cannon

15. Birthplace Seaford Delaware

16. Informant Wm. Keads of John B. Parson Home

17. Buried Date thereof March 18-47
(Burial, cremation, or removal, Whitt?) (month) (day) (year)

Cemetery or crematory Old Fellows Cem.

Location Seaford Delaware

18. Funeral director Hillman & Co. Walter R. Hillman

Address Salisbury Maryland

19. 3/17/47 19 47 Registrar Harriet G. Johnson

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 16th 1947 at 10:55 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1945 to March 16 1947

and that I last saw him alive on March 15 1947

Immediate cause of death Pulmonary Tuberculosis DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Lucas A. Smith M. D. or other

Address Salisbury Md Date signed 3-17-47

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2-35

Dr. Gilmore

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

CERTIFICATE OF DEATH

03304

Reg. Dist. No. 383

1. PLACE OF DEATH: McComie Co
County Salisbury
City or town (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: 407. Camden Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County McComie
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 407. Camden Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Rudolph Charles Butler

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
6. (b) Name of husband or wife Mary R. Butler
7. Birth date of deceased (mo., day, yr.) Feb. 18 - 1899 6. (c) If alive, give age 37 years

8. AGE: 48 Years 0 Months 24 Days (If less than one day) hrs. min.

9. Birthplace Princeton Anne Md.
(Town, county, and state)
Salisbury

10. Usual occupation

11. Industry or business

FATHER 12. Name Ledney Butler

13. Birthplace R.D. 1 Princeton Anne Md.

MOTHER 14. Maiden name Mary Packard

15. Birthplace Princeton Anne Md.

16. Informant Mrs. Mary R. Butler

Address 407. Camden Ave. Salisbury

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof Mar 5 - 47

Cemetery or crematory Mt. Olive Church

Location McComie Co. Md.

18. Funeral director Hillman & Co. Walter R. Hillman

Address Salisbury Maryland

19. Date rec'd by registrar 3/6/47

20. Signature David J. Gilmore M.D.

Address 301 N. Division

MEDICAL CERTIFICATION

20. DATE OF DEATH March 2nd 1947 at 11:45 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 27 1946 to March 2 1947 and that I last saw him alive on March 2 1947

Immediate cause of death Cerebral Hemorrhage DURATION minutes

Due to Hypertension, Essential Cerebral Arteriosclerosis before

Due to Hypertensive Heart Disease 4 months

Other conditions (Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Injured at work?

23. SIGNATURE David J. Gilmore M.D.

Address 301 N. Division

Date signed March 4, 1947

MARGIN RESERVED FOR BINDING

VS A15 9.45.15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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MAR 11 1947
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2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 157-2

CERTIFICATE OF DEATH

03305

Reg. Dist. No. 333

1. PLACE OF DEATH:

County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 hrs. 11 min
Hospital, institution, or street address where death occurred:
Peninsula General Hospital
How long in hospital or institution? 5 hrs. 11 min

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. ✓
(If rural, give LOCATION)
2.(a) If veteran, name war. ✓

3. (a) FULL NAME

Baby Boy Chronister

3. (b) Social Security Number

✓

4. Sex Male 5. Color of face W 6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife ✓

7. Birth date of deceased (mo., day, yr.) March 29, 1947
6.(c) If alive, give age. ✓ years

8. AGE: Years Months Days If less than one day
5 hrs. 11 min.

9. Birthplace Salisbury, Wicomico, Maryland
(Town, county, and state)

10. Usual occupation None

11. Industry or business ✓

12. Name Chronister, Mr. Robert

13. Birthplace York, Pennsylvania

14. Maiden name Leas, Jeannette Ellen

15. Birthplace York, Pennsylvania

16. Informant Robert Chronister

Address Salisbury, Md.

17. Burial Date thereof 4/2/47
(Burial, cremation, or removal. Which) (month) (year)

Comotory or crematory Passes

Location Salisbury, Md.

18. Funeral director The Kiel & Johnson Co.

Address Salisbury, Md.

19. 4/18/47 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 29 1947 at 6:14 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19

and that I last saw him alive on 19

Immediate cause of death Immediate absence of DURATION

kidneys & bladder

Due to Immediate absence of

Due to kidneys & bladder

Other conditions Immediate absence of

(Include pregnancy within 3 months of death)

Major findings of operations Immediate absence of

Date of op. Immediate absence of

Autopsy results Immediate absence of

PHYSICIAN: Please underline the cause in which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Immediate absence of Date of Immediate absence of

Where did injury occur? Immediate absence of (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Immediate absence of

Means of injury Immediate absence of injured at work?

23. SIGNATURE Frederic A. Jones M. D. or other

Address Salisbury, Md. Date signed 4-2-47

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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APR 12 1947

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

W. Kilmore

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 784

CERTIFICATE OF DEATH

03306

Reg. Dist. No. 393

1. PLACE OF DEATH:

County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Peninsula General Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Wicomico
City or town Parramatta
(If outside city or town limits, write RURAL and give nearest town)

Street No. P.O. #1.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

brother Mr. James Isaac

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

male white Widower

6. (b) Name of husband or wife Jennie Crouch6. (c) If alive, give age Dead years7. Birth date of deceased (mo., day, yr.) Oct. 8-1878

8. AGE: 68 Years 4 Months 9 Days If less than one day
..... hrs. min.

9. Birthplace Salisbury Maryland
(Town, county, and state)10. Usual occupation Poultry raiser11. Industry or business Chicken Farm12. Name Isaac James Crouch13. Birthplace Wicomico Co. Md.14. Maiden name Indiana Taylor15. Birthplace Siloam Maryland16. Informant Mrs. Madeline EdwinAddress P.O. #1, Parramatta, Md.17. Burial, cremation, or removal (which?) Buried Date thereof May 20-1947
(month) (day) (year)Cemetery or crematory Shad Point Cem.Location Shad Point Maryland18. Funeral director Hillman & G. Walter R. HillmanAddress Salisbury Maryland19. 3/20/47 Date rec'd by registrar20. H. C. Barrett Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 17-1947 at 6:35 p.m.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 15-1947 to March 17-1947and that I last saw him alive on March 17-1947

Immediate cause of death arteriosclerotic heart disease DURATION 1 year
Symptoms

Due to

Due to

Other conditions Multiple Pulmonary Infarcts DURATION 5 days
Symptoms

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results See above (Myocardial thrombosis)

PHYSICIAN: Please underline the cause in which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE David J. Kilmore M.D.Address 301 N. Division Date signed Apr 20 1947

Registrar

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APR 12 1947

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 97

CERTIFICATE OF DEATH

Reg. Dist. No. 3930

1. PLACE OF DEATH:

County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 years
Hospital, institution, or street address where death occurred:
John B. Parsons Home
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. John B. Parsons Home
(If rural, give LOCATION)
2.(a) If veteran, name war.....

3. (a) FULL NAME

Roberta Lee Dixon

3. (b) Social Security Number

4. Sex Female 5. Color or race white 6.(a) Single, married, widowed, or divorced single
6.(b) Name of husband or wife.....
6.(c) If alive, give age.....years
7. Birth date of deceased (mo., day, yr.) Dec. 3, 1870
8. AGE: Years 77 Months 3 Days 8 If less than one day.....hrs.min.

9. Birthplace Matther Co. Va.
(Town, county, and state)
10. Usual occupation none
11. Industry or business.....
12. Name George W. Dixon
13. Birthplace Va.
14. Maiden name Anne W. Davis
15. Birthplace Va.

16. Informant John B. Parsons Home
Address Salisbury, Md.
17. Burial Date thereof 3/13/47
(Burial, cremation, or removal, Which?) (month) (day) (year)
Cemetery or crematory Parsons Cemetery
Location Salisbury, Md.

18. Funeral director The Hill & Johnson Co.
Address Salisbury, Md.

19. 3/13 1947 H. J. Harrison
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 11, 1947 1947 430 A
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19
and that I last saw him alive on March 11, 1947
Immediate cause of death Heart not been patient before DURATION

Due to.....
Due to.....
Other conditions.....
(Include pregnancy within 3 months of death)

Major findings of operations.....
Date of op.
Autopsy results.....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide..... Date of.....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Carrie I. Hearn
M. D. or other
Address..... Date signed.....

MARGIN RESERVED FOR BINDING

9.45.15M

VS. 415

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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APR 7 1947

BUREAU OF

2-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Line correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 85

CERTIFICATE OF DEATH

3308

Reg. Dist. No. 11

1. PLACE OF DEATH:

County WicomicoCity or town Delmar
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 25 yrs.

Hospital, institution, or street address where death occurred:

11 E. Chestnut St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Delaware County WicomicoCity or town Delmar
(If outside city or town limits, write RURAL and give nearest town)Street No. 11 E. Chestnut St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Estella Farmer Donnelly

3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Edward J. Donnelly Sr.6. (c) If alive, give age 64 1/2 years

7. Birth date of

deceased (mo., day, yr.)

Aug 18 1889

8. AGE:

Years 57

Months

Days

If less than one day

hrs. min.

9. Birthplace

Oxford Maryland
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Home

12. Name

Samuel E. Conroy

13. Birthplace

Balta Ind.

14. Maiden name

Anna Mason

15. Birthplace

Oxford Ind.

16. Informant

Edward J. Donnelly Sr.

Address

Delmar, Del.

17. (Burial, cremation, or removal. Which?)

BuriedDate thereof 3/24/47

(month) (day) (year)

Cemetery or crematory

St. John's

Location

Delmar, Del.

18. Funeral director

H. E. Gansel Co.

Address

Delmar, Del.

19. (Date rec'd by registrar)

3-22-47

Registral

Harry E. Anderson

MEDICAL CERTIFICATION

20. DATE OF DEATH

Jan 21 1947 at 8:05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 1946 to March 21 1947and that I last saw him alive on March 19 1947

Immediate cause of death

cerebral hemorrhage

DURATION

2 days

Due to

arteriosclerosis
hypertension, essential

Due to

hemiplegia

Other conditions

hemiplegia

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

H. V. Fowler, M.D.

23. SIGNATURE

Delmar, Md.

M. D. or other

Address 3-22-47

Date signed

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1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (121)

CERTIFICATE OF DEATH

Reg. Dist. No. 339

03309

1. PLACE OF DEATH:

County Wicomico
City or town Salisbury, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Peninsula General Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Somerset
City or town Princess Anne
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

None

3. (a) FULL NAME

Drew, Mr. George Stott

3. (b) Social Security Number

None

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

widower

6. (b) Name of husband or wife

6. (c) If alive, give age. years

7. Birth date of deceased (mo., day, yr.)

Sept. 20, 1869

8. AGE:

77 Years

6 Months

11 Days

hrs.

min.

9. Birthplace

New York, N. Y.
(Town, county, and state)

10. Usual occupation

architect

11. Industry or business

MOTHER

FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. (Burial, cremation, or removal. Which?)

Date thereof

Cemetery or crematory

Location

18. Funeral director

Address

19. (Date recd. by registrar)

19. H. T. Larnett & Johnson

Registrar

Address

Date signed

3-8-47

Salisbury, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 8 1947, at 1:15 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 2 1947, to March 8 1947

and that I last saw him alive on March 8 1947

Immediate cause of death

Respiratory failure

Burning building not improved. Sugg.

Due to 2nd degree burns 6 days

(40% of body)

Due to

Other conditions Shock

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert R. Starr

M. D. Salisbury, Md.

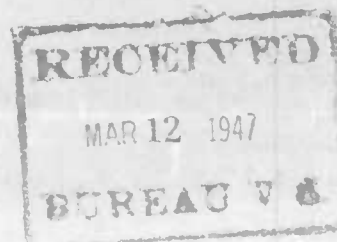
Date signed 3-8-47

MARGIN RESERVED FOR BINDING

9.45.15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1-35

Dr. Rademaker

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03310

Reg. Dist. No. 3300

1. PLACE OF DEATH:

County.....Wicomico

City or town.....Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Died enroute to Peninsula General Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....Maryland County.....Wicomico

City or town.....Salisbury Md. Route # 3
(If outside city or town limits, write RURAL and give nearest town)

Street No. R.F.D. #3 Salisbury Md.

(If rural, give LOCATION)

2.(a) If veteran, name war.....World War 2 (Navy)

3. (a) FULL NAME

Stansbury Farlow

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Divorced

6. (b) Name of husband or wife

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

Nov. 10. 1910

8. AGE:

Years 36

Months 5

Days 2

It less than one day

.....hrs.min.

9. Birthplace.....Salisbury Md. Route # 3

(Town, county, and state)

Fireman Locomotive

10. Usual occupation.....Penny, Railroad

11. Industry or business

FATHER

12. Name.....Henry L. Farlow

13. Birthplace.....Near Pittsville Md.

MOTHER

14. Maiden name.....Martha E. Holloway

15. Birthplace.....Near Pittsville Md.

16. Informant.....Mrs. Martha E. Farlow,
Salisbury Md. Route # 3

Address

17. Burial Date thereof.....Mar. 25th. 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory.....Parsons Cemetery

Location.....Salisbury Md.

18. Funeral director.....Holloway & Co Per. *Martha Holloway*
Address.....520 E. Church St. Salisbury Md.19. 3/25/47 H. H. Harrison Registrar
(Date read by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH.....March 22 1947 at 10:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him.....12.....to.....19.....

Immediate cause of death.....Fractured skull
Brain injury

DURATION

Sudden death

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....None

Date of op.

Autopsy results.....None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....Accident Date of 3/22/47

Where did injury occur?.....Salisbury Wicomico Md
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....Highway

Injury.....car skidded into Injured at work? No

23. SIGNATURE.....Dr. Rademaker M.D. or other

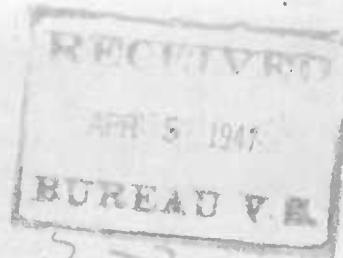
Address.....Salisbury Md Date signed.....3/23/47

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. legibly

Physicians: please write the causes of death clearly and legibly

is especially important.

MARGIN RESERVED FOR BINDING

correct age

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 107

CERTIFICATE OF DEATH

Reg. Dist. No. 353

1. PLACE OF DEATH:

County Wicomico Co
 City or town Salisbury Md
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 38 years
 Hospital, institution, or street address where death occurred:
2 days
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State md County Wicomico Co
 City or town Salisbury Md
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2. (a) If veteran, name war _____

3. (a) FULL NAME

Lenore Fields

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

male Col Married

6. (b) Name of husband or wife Lillie Fields

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Jan 2, 1895

8. AGE: Years Months Days If less than one day
52 2 29 — hrs. — min.

9. Birthplace Danvers Quarter
 (Town, county, and state)
Danvers

10. Usual occupation Farmer

11. Industry or business none

12. Name Geo W. Fields

13. Birthplace Danvers Quarter

14. Maiden name Jane Parsons

15. Birthplace unknown

16. Informant Lillie Fields

Address Truittland Md

17. Burial Date thereof Apr 2, 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Cem. Pariale Family

Location Truittland

18. Funeral director Broker W. Wuth

Address 404 Duke St Salisbury

19. H/8 47 Barrie L. Johnson
 (Date and by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/30 1947 at _____ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9-27 1947, to 3-30 1947
 and that I last saw him alive on 3-30 1947

Immediate cause of death _____ DURATION

Acute cardiac failure
 Due to _____

Brucella pyaemia
 Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

_____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE _____ M. D. or other

Address Salisbury Md Date signed 3-31-47

10 10-E 10 10-2
10 10-E 10 10-2

Unit records for
10-10-47

RECEIVED
APR 12 1947
BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03312

Reg. Dist. No. 3300

1. PLACE OF DEATH:

County Wicomico
 City or town Mardela Springs - Rural
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life
 Hospital, institution, or street address where death occurred:
San Domingo
 How long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Wicomico
 City or town Mardela Springs - Rural
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. San Domingo
 (If rural, give LOCATION)
 2.(a) If veteran, name war -

3. (a) FULL NAME

Jeanette B. Fooks

3. (b) Social Security Number

None

4. Sex Female 5. Color or race Colored 6.(a) Single, married, widowed, or divorced Widowed
 6.(b) Name of husband or wife Edward Fooks
 6.(c) If alive, give age - years
 7. Birth date of deceased (mo., day, yr.) April 20, 1878
 8. AGE: Years 68 Months 10 Days 24 If less than one day - hrs. - min.

8. Birthplace Wicomico County, Maryland
 (Town, county, and state)
 10. Usual occupation Housework
 11. Industry or business None
 12. Name Jane Fooks
 13. Birthplace Wicomico County, Maryland
 14. Maiden name Mary Elizabeth Brown
 15. Birthplace Wicomico County, Maryland

16. Informant Mabel Lee Fooks
 Address Mardela Springs, Maryland, R.F.D.
 17. Burial Date thereof March 18, 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory San Domingo Cemetery
 Location Near Sharptown, Maryland
 18. Funeral director J. J. Trupton and Son
 Address Federalburg, Maryland
 19. 3/18/47 W. H. Robertson
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 14 1947, at 6 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 10 1947 to Mar 14 1947and that I last saw him alive on Mar 14 1947Immediate cause of death Chronic nephritis

DURATION

34 yrsDue to -Due to -Other conditions Metastatic neoplasms (2)

(Include pregnancy within 3 months of death)

Major findings of operations -Date of op. -Autopsy results -

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide - Date of -Where did injury occur? - (City or town) - (County) - (State)Injured at home, farm, industry, public place (where?) -Means of injury - Injured at work? -23. SIGNATURE J. S. Kuhlman M. D. or otherAddress Sharptown Md Date signed 3/15/47

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MAR 20 1947

BUREAU

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03313

Reg. Dist. No. 33/0

1. PLACE OF DEATH:

County Wilcomica
City or town Quantico Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? about 10 years
Hospital, institution, or street address where death occurred: no
How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Md County Wilcomica
City or town Quantico Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. no
(If rural, give LOCATION) no
2.(a) If veteran, name war. no

3. (a) FULL NAME

Martha A Gale

3. (b) Social Security Number

no

4. Sex Female 5. Color or race A.G. 6.(a) Single, married, widowed, or divorced Widower

6.(b) Name of husband or wife John Gale

7. Birth date of deceased (mo., day, yr.) about 1861

8. AGE: Years about 86 Months no Days no If less than one day no hrs. no min. no

9. Birthplace Palks Road Somerset
(Town, county, and state)

10. Usual occupation none

11. Industry or business Housewife

12. Name Henry Wilson

13. Birthplace Palks Road Somerset Va

14. Maiden name Amanda Washell

15. Birthplace Palks Road Somerset Va

16. Informant Mrs. White Winder

Address Quantico Md

17. Burial Burial Date thereof Apr 3 - 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Palks Road Somerset Va

Location near Princess Anne Md

18. Funeral director James A. Bellward

Address Salisbury Md

19. April 3 19 47 Mrs M. Wilson
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 31 19 47 at 4:50 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 29, 19 46 to March 31, 19 47

and that I last saw him alive on March 31, 19 47

Immediate cause of death Respiration Failure DURATION 3 hrs.

Due to Cerebral hemorrhage 2 months

Due to arteriosclerosis

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert J. Shaw M. D. or other

Address 302 N. Dawson St Date signed 4/1/47

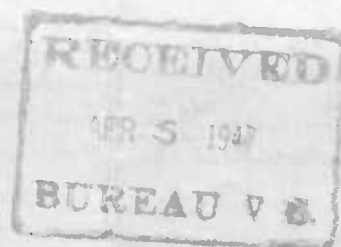
Salisbury, Md

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Write correct age especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 9350

CERTIFICATE OF DEATH

Reg. Dist. No. 3330

1. PLACE OF DEATH:

County Wicomico
 City or town Salisbury
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 88 years
 Hospital, institution, or street address where death occurred:
230 Newton St.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Wicomico
 City or town Salisbury
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced widowed
 6.(b) Name of husband or wife Elizabeth Ellen Harvey
 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) Feb. 16, 1859.
 8. AGE: Years 88 Months 0 Days 27 If less than one day _____ hrs. _____ min.

9. Birthplace Dorchester Co. Md.
 (Town, county, and state)
 10. Usual occupation retired
 11. Industry or business carpenter
 FATHER
 12. Name William Harvey
 13. Birthplace Caroline Co Md.
 MOTHER
 14. Maiden name Catherine Dayton
 15. Birthplace Dorchester Co Md.

16. Informant J. Edgar Harvey
 Address Salisbury, Md.
 17. Burial Date thereof 3/17/47
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory Parsons Cemetery
 Location Salisbury, Md.
 18. Funeral director The Hill & Johnson Co.
 Address Salisbury, Md.

19. 3/17 19 47 Harriet E. Johnson
 (Date read by registrar) Registrar

MEDICAL CERTIFICATION

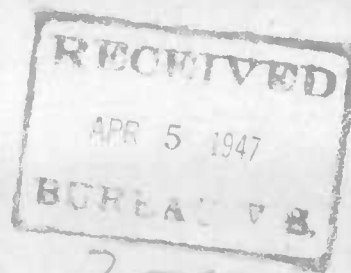
20. DATE OF DEATH March, 14, 1947, at 7:45 A.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 1 1947 to Mar 14 1947
 and that I last saw him alive on Mar 1 1947
 Immediate cause of death Arteriosclerosis
 DURATION 2
 Due to _____
 Due to _____
 Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings of operations _____
 Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____
 (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work?

23. SIGNATURE Harriet E. Johnson M. D. or other _____
 Address Salisbury, Md. Date signed Mar 15



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (U)

CERTIFICATE OF DEATH

Reg. Dist. No. 3760

1. PLACE OF DEATH:

County WicomicoCity or town Delmar
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 6 mos.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WicomicoCity or town Delmar
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Kona Esther Hastings

3. (b) Social Security Number

4. Sex Female5. Color or race White6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Gardner H. Hastings7. Birth date of deceased (mo., day, yr.) Jan. 25 - 18916. (c) If alive, give age 51 years8. AGE: Years 56 Months _____ Days _____ If less than one day _____ hrs. _____ min.9. Birthplace Sussex County, Del.
(Name, county, and state)10. Usual occupation House work11. Industry or business Home12. Name Samuel Miller13. Birthplace Sussex County, Del.14. Maiden name Betty Hastings15. Birthplace Sussex County, Del.16. Informant Gardner H. HastingsAddress Delmar Del17. Burial Date thereof 3-10-47
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory M. P.Location Delmar Del18. Funeral director W. S. Grand CoAddress Delmar, Del.March 10, 1947 Harry E. Hudson
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 8 19 47 at 6:30 A.M.21. I CERTIFY that death occurred on the date above stated, that I attended deceased from January 19 46 to March 19 47and that I last saw him alive on March 8 19 47Immediate cause of death Myocardial failure DURATION _____Due to arteriosclerotic myo-cardosis

Due to _____

Other conditions Diabetes mellitus

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE L. V. Fohler, M.D. M. D. or other _____Address Schwar, Del Date signed 3-10-47

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MAR 12 1947
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1-35-

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1226

CERTIFICATE OF DEATH

03316

Reg. Dist. No. 5530

1. PLACE OF DEATH:

County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Peninsula General Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Wicomico
City or town Delmar
(If outside city or town limits, write RURAL and give nearest town)
Street No. R.F.D. #1
(If rural, give LOCATION)
2.(c) If veteran, name war no

3. (a) FULL NAME

Hutton, Althea
4. Sex Female 5. Color or race Colored 6.(a) Single, married, widowed, or divorced Married
6.(b) Name of husband or wife Hutton, Andrew
6.(c) If alive, give age..... years

3. (b) Social Security Number

Don't know

7. Birth date of deceased (mo., day, yr.) about 1896
8. AGE: Years about 51 Months Days If less than one day
.....hrs.min.

9. Birthplace Delmar Md
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Same as above

12. Name Rosa R. Burns

13. Birthplace Personship

14. Maiden name Gertrude Sprauferd

15. Birthplace Quantico Md

16. Informant Caraine Hallaway

Address Delmar Md

17. Burial Date thereof Mar. 7 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Union

Location Delmar Md

18. Funeral director James H. Stewart

Address Salisbury Md

19. 3/10 1947
(Date registered) (month) (day) (year)

Registrar John

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-4-47 19....., at..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3-2- 1947 to 3-4 1947
and that I last saw h. R.R. alive on 3-4 1947

Immediate cause of death Intestinal obstruction DURATION

Due to adhesions (post-operative)

Due to.....

Other conditions acute cholecystitis

(Include pregnancy within 3 months of death)

Major findings of operations Intestinal obstruction

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Luiza Smith M.D. or other

Address Salisbury Md Date signed 3-7-47

MARGIN RESERVED FOR BINDING

9.45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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MAR 27 1947

BUREAU OF

2-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 33

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County WicomicoCity or town Willards
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? LifetimeHospital, institution, or street address where death occurred: R.D.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD. County WicomicoCity or town Willards
(If outside city or town limits, write RURAL and give nearest town)Street No. R.D.
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Benjamin Ree Ham

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Maudie J. Ham6. (c) If alive, give age 64 years

7. Birth date of

deceased (mo., day, year) Aug. 17-1881

8. AGE:

Years 65Months 6Days 24

If less than one day

hrs. min.

9. Birthplace

Willards Md.
(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

FATHER

12. Name

Charles R. Ham

13. Birthplace

Willards Maryland

MOTHER

14. Maiden name

May Lynn Wrenn

15. Birthplace

Willards Maryland

16. Informant

Mr. Maudie J. Ham

Address

R.D. Willards Maryland

17. Burial

(Burial, cremation, or removal: Which?) Burial

Date thereof

March 13-1947
(month) (day) (year)

Cemetery or crematory

Wrenn Cemetery

Location

Willards Maryland

18. Funeral director

Holloway & Co. Walter R. Holloway

Address

Salisbury Maryland

19. Date

3/13/47

(Date received by registrar)

19. Date

3/13/47

19. Date

3/13/47

MEDICAL CERTIFICATION

20. DATE OF DEATH

March 11-1947

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb. 27, 1947 to day of deathand that I last saw him alive on 3-11-47

Immediate cause of death

Influenza

DURATION

2 wks

Due to

Due to

Other conditions

Ch. inf. & tox.Ad. inf. & tox.

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Frank R. Lewis, M.D.

M. D. or other

Address

Willards Maryland

Date signed

3-12-47

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APR 7 1947

BUREAU OF

2-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (332)

CERTIFICATE OF DEATH

03318

Reg. Dist. No. 333

1. PLACE OF DEATH:

County WicomicoCity or town Sabaskon
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 daysHospital, institution, or street address where death occurred:
Chesapeake General Hosp.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WicomicoCity or town Delmar
(If outside city or town limits, write RURAL and give nearest town)Street No. 9 East
(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (a) FULL NAME

Carrie Lee Hitchens

3. (b) Social Security Number

221-03-11134. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed6.(b) Name of husband or wife Ignacio Lee Hitchens6.(c) If alive, give age — years7. Birth date of deceased (mo., day, yr.) Oct 18 18758. AGE: Years 71 Months — Days — If less than one day — hrs. — min.9. Birthplace Sussex Del
(Town, county, and state)10. Usual occupation House work11. Industry or business Home12. Name John Louis Elliott13. Birthplace Sussex County Del14. Maiden name Emma Elliott15. Birthplace Sussex County Del16. Informant Dr. J. G. SeftonAddress Delmar Del17. Buried Date thereof 3/25/47
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Old FellowsLocation Sussex Delmar18. Funeral director Dr. S. MarshallAddress Delmar Del19. 3/35/47 19. 47 Registrar Barrett E. Johnson
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 23 19. 47 at FA M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1 19. 47 to March 23 19. 47and that I last saw him alive on March 22 19. 47Immediate cause of death Myocarditis DURATIONSubacuteDue to —Due to —Other conditions Malnutrition

(Include pregnancy within 3 months of death)

Major findings of operations — Date of op. —Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —Means of injury — Injured at work? —23. SIGNATURE H. V. Lohr M. D. or otherAddress Delmar Del Date signed 3-25-47

RECEIVED

APR 12 1947

BUREAU 18

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-6)

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County... WilkesCity or town... Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Peninsula General HospitalHow long in hospital or institution? 3 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Del. County... Sand.City or town... Ventnor, rural
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Holbrook, Elijah, Sr.

3. (b) Social Security Number

4. Sex

male

5. Color or race

C

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Eva H. Holbrook

7. Birth date of

deceased (mo., day, yr.)

1884

8. AGE:

Years 63

Months

Days

If less than one day

hrs. min.

9. Birthplace

Ventnor, Delaware, Md.

(Town, county, and state)

10. Usual occupation

farmer

11. Industry or business

FATHER

MOTHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. (Burial, cremation, or removal. Which?)

Date thereof

Cemetery or crematory

Location

18. Funeral director

Address

19. (Date rec'd by registrar)

20. DATE OF DEATH

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

Immediate cause of death

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed

MEDICAL CERTIFICATION

20. DATE OF DEATH... March 22, 1947 at 7 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

3/9 1947 to 3/22 1947and that I last saw him alive on 3/21 1947

Immediate cause of death

Uraemia

DURATION

2 weeks

Due to

Chronic nephritis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Oliver T. Tucker, M.D.Address Salisbury, Md. Date signed 3/24/47

RECEIVED

APR 12 1947

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 63-6

03319

CERTIFICATE OF DEATH

Reg. Diat. No. 933

1. PLACE OF DEATH:

County Wicomico
 City or town Fruitland, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life
 Hospital, institution, or street address where death occurred: no
 How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Wicomico
 City or town Fruitland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. no
 (If rural, give LOCATION)
 2. (a) If veteran, name war no

3. (a) FULL NAME

Mastella Hopkins
 4. Sex Female 5. Color or race a. a 6. (a) Single, married, widowed, or divorced widow

6. (b) Name of husband or wife Lewis Hopkins
Dead 6. (c) If alive, give age no years
 7. Birth date of deceased (mo., day, yr.) about 1873

8. AGE: Years 74 Months Days If less than one day
 hrs. min.

9. Birthplace Fruitland
 (Town, county, and state)

10. Usual occupation Housekeeper

11. Industry or business same as above

12. Name Carl Black

13. Birthplace Fruitland

14. Maiden name Caroline Dashiell

15. Birthplace Fruitland Md

16. Informant Samuel Harmon

Address Fruitland, Maryland

17. Burial Date thereof 3-6-47
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Wt. Olivet

Location Fruitland, Md

18. Funeral director James H. Stewart

Address Salisbury Md

19. 3/6 19 47 Registrar Local

(Date rec'd by registrar)

3. (b) Social Security Number

no

MEDICAL CERTIFICATION

20. DATE OF DEATH March 4 19 47 at 9:30 a. m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from medical examination 19 47

and that I last saw him alive on 19 47

Immediate cause of death Chronic myocarditis

Due to large toxic bacteria

Due to many

Other conditions years

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations none

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE for Padmanabhu Md

Address Deputy Med Exam

Date signed 3/6/47

RECEIVED

MAR 12 1947

BUREAU V. S.

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 61

CERTIFICATE OF DEATH

03320

Reg. Dist. No. 3300

1. PLACE OF DEATH:

County Wicomico
City or town Near Mardela Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Sharptown Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Wicomico
City or town Near Mardela
(If outside city or town limits, write RURAL and give nearest town)
Street No. Sharptown Road
(If rural, give LOCATION)
2. (a) If veteran, name war

3. (a) FULL NAME

Maggie Ellen Howard

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Thomas B. Howard

7. Birth date of deceased (mo., day, yr.) Dec. 7th. 1874 8. (c) If alive, give age 73 years

8. AGE: Years 72 Months 3 Days 15 If less than one day
.....hrs.min.

9. Birthplace R. D. Quantico Md.
(town, county, and state)

10. Usual occupation House Work

11. Industry or business At Home

12. Name George H. Riggins

13. Birthplace R. D. Mardela Md.

14. Maiden name Roxie A. Twilley

15. Birthplace R. D. Hebron Md.

16. Informant Mrs. Elizabeth Esham
Address Mardela Md.

17. Burial (Burial, cremation, or removal. Which?) Mar. 25th. 1947
(month) (day) (year)

Cemetery or crematory Mardela Cemetery

Location Mardela Md.

18. Funeral director Holloway & Co. Per. J. Holloway

Address 520 East Church St Salisbury Md.

19. 3/25/47 (Date rec'd by registrar) Registrar W. H. Robertson

MEDICAL CERTIFICATION

Mar. 22nd 47

20. DATE OF DEATH 19..... 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him medical summer certificate 19.....
Immediate cause of death Coronary Thrombosis

Other conditions Chronic Myocarditis

Due to Diabetes Mellitus

Due to unknown

Other conditions Diabetes Mellitus

(Include pregnancy within 3 months of death)

Major findings of operations none

Date of op. none

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Causes of injury Injured at work?

23. SIGNATURE J. B. Riggins M. D. or other

Address Salisbury Md Date signed 3/25/47

MARGIN RESERVED FOR BINDING

9.45.15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 27 1947

BUREAU

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 3330

1. PLACE OF DEATH:

County FrederickCity or town Fruitland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County FrederickCity or town Fruitland
(If outside city or town limits, write RURAL and give nearest town)Street No. Main street
(If rural, give LOCATION)

2(a) If veteran, name war

3. (a) FULL NAME

Richard Allen Johnson

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

single (infant)

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

Nov. 4th 1946

8. (c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

47

hrs.

min.

9. Birthplace

Fruitland Maryland
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

Orville Lee Johnson

13. Birthplace

R.D. #1. Salby Md.

MOTHER

14. Maiden name

Emma Johnson

15. Birthplace

R.D. Prince Anne Md.

16. Informant

My. Emma Johnson

Address

Fruitland Maryland

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

Nov. 13-47
(month) (day) (year)

Cemetery or crematory

Parsons Cemetery

Location

Salby Md.

18. Funeral director

William G. Walter R. Holmway

Address

Salby Maryland

19.

(Date rec'd by registrar)

3/13/47

19

W. G. Walter R. Holmway

Registrar

MEDICAL CERTIFICATION

DATE OF DEATH March 11th 47 at 2 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

3-10-4719. 3-11-47 19.

and that I last saw him alive on

3-11-47

19.

Immediate cause of death

Pneumonia - Lobar -Bilateral

DURATION

2 da

Due to

Due to

Other conditions

Hydrocephalus CongenitalClubbed feet

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Lee L. Lawry, M.D.

M. D. or other

Address

Fruitland MdDate signed 3-12-47

RECEIVED

APR 7 1947

BUREAU V B

2-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Write the correct age especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03322
Reg. Dist. No. 333

1. PLACE OF DEATH: County... <u>Salisbury</u> City or town... <u>McComie</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? <u>2 year</u> Hospital, institution, or street address where death occurred: <u>Res. Ben. Wright.</u> How long in hospital or institution? <u>3</u>		2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State... <u>md.</u> County... <u>McComie</u> City or town... <u>Salisbury</u> (If outside city or town limits, write RURAL and give nearest town) Street No. <u>E. Pine St.</u> <u>Extended</u> (If rural, give LOCATION) 2.(a) If veteran, name war...	
3.(a) FULL NAME <u>Charles Wesley Jones</u>		3.(b) Social Security Number	
4. Sex <u>Male</u>	5. Color or race <u>White</u>	6.(a) Single, married, widowed, or divorced <u>Married</u>	
6.(b) Name of husband or wife <u>Natilda Jones</u>			
7. Birth date of deceased (mo., day, yr.) <u>Aug. 21st 1874</u>			
8. AGE: <u>72</u> Years <u>6</u> Months <u>15</u> Days It less than one day hrs. min.	2D. DATE OF DEATH <u>March 6th 1947</u> at <u>6:55</u> P.M.		
9. Birthplace <u>Harrington Delaware</u> (Town, county, and state)		21. I CERTIFY that death occurred on the date above stated: that I attended deceased from <u>2 January 1947</u> to <u>6 March 1947</u> and that I last saw him alive on <u>3 Jan March 1947</u>	
10. Usual occupation <u>Labourer</u>		Immediate cause of death <u>Squamous cell carcinoma of rectum & anus</u>	
11. Industry or business <u>Joshua Jones</u>		Due to <u>Generalized metastatic disease</u>	
12. Name <u>P.O. Harrington Delaware</u>		Other conditions <u>Generalized metastatic disease</u>	
13. Birthplace <u>May Adams</u>		(Include pregnancy within 3 months of death)	
14. Maiden name <u>Mr. Glen Steele</u>		Major findings of operations <u>Squamous cell carcinoma of anus</u>	
15. Birthplace <u>E. Pine St. Salisbury Md</u>		Date of op. <u>1.3.47</u>	
16. Informant <u>Buried</u>		Autopsy results <u>1.7.47</u>	
17. (Burial, cremation, or removal. Which?) <u>Harrington Del.</u>		PHYSICIAN: Please underline the cause to which death should be charged statistically.	
18. Funeral director <u>Walter R. Williams</u>		22. VIOLENCE: If death was due to external causes, fill in the following:	
Address <u>Salisbury Maryland</u>		Accident, suicide, or homicide... Date of...	
19. (Date rec'd by registrar) <u>3/18/47</u>		Where did injury occur? (City or town) (County) (State)	
20. Registrar <u>Walter R. Williams</u>		Injured at home, farm, industry, public place (where?) Injured at work?	
21. SIGNATURE <u>Henry B. Brick</u>		Means of injury Injured at work?	
22. Address <u>304 N. Division St.</u>		Date signed <u>7 Mar 47</u>	

RECEIVED

MAR 12 1947

BUREAU OF

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 489

CERTIFICATE OF DEATH

Reg. Dist. No. 0332833

1. PLACE OF DEATH:

County WicomicoCity or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Peninsula General Hospital
How long in hospital or institution? 78 days - 121 hours.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WicomicoCity or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)Street No. 423 Elled Street
(If rural, give LOCATION) na

2.(a) If veteran, name war

3. (a) FULL NAME

John Jones

4. Sex

male

5. Color or race

col.

6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife

Ola Jones
yes Wicomico

7. Birth date of

deceased (mo., day, yr.) about 1891

8. AGE:

about 56

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Unknown
(Town, county, and state)

10. Usual occupation

Laborer

11. Industry or business

Same as above

FATHER

12. Name

Unknown

13. Birthplace

Unknown

MOTHER

14. Maiden name

Unknown

15. Birthplace

Unknown

16. Informant

Ola Jones

Address

Salisbury MD

17. Burial

Public

Date thereof

Apr 1 1947
(month) (day) (year)

Cemetery or crematory

Salisbury MD

Location

Salisbury MD

18. Funeral director

James L. Stewart

Address

Salisbury MD

19. (Date reg'd by registrar)

4/1/47

Registral

John L. Stewart

Address

Salisbury MD

23. SIGNATURE

John L. Stewart

M. D. or other

Salisbury MD

Date signed

4/1/47

MEDICAL CERTIFICATION

20. DATE OF DEATH March 31 19 47 at 7 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from medical exam to certified 19 47and that I last saw him alive on March 31 19 47Immediate cause of death Carcinoma of PouchesDURATION 6 mosOther conditions Bronchopneumonia

3 days

(Include pregnancy within 3 months of death)

Major findings of operations naDate of op. naAutopsy results as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: NoAccident, suicide, or homicide. Date of na

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Salisbury MDDeputy Med Examin23. SIGNATURE John L. StewartM. D. or other Salisbury MDDate signed 4/1/47

RECEIVED

APR 12 1947

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

03324

2600

1. PLACE OF DEATH:

County WorcesterCity or town Salisbury, Md.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 9 hours

Hospital, institution, or street address where death occurred:

James Venton, Md.How long in hospital or institution? 9 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County SamuelCity or town Venton
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2. (a) If veteran, name war _____

3. (a) FULL NAME

Lou Andrew Jones

3. (b) Social Security Number

4. Sex male5. Color or race Colored6. (a) Single, married, widowed, or divorced single

6. (b) Name of husband or wife _____

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) August 3, 19298. AGE: Years 17 Months 7 Days 1 If less than one day _____ hrs. _____ min.9. Birthplace Venton, Md.
(Town, county, and state)10. Usual occupation labor

11. Industry or business _____

12. Name Ellie Jones13. Birthplace Venton, Md.14. Maiden name Blanch Smith15. Birthplace Venton, Md.16. Informant Ellie JonesAddress Venton, Md.17. Burial Date thereof March 8, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory GraceLocation Venton, Md.18. Funeral director William H. James Jr.Address Princess Anne, Md.19. March 10, 47 R. J. Johnson
(Date rec'd by registrar) (month) (day) (year) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 5, 1947 at 1:20 PM

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from _____ 19____ to _____ 19____

and that I last saw him _____ alive on _____ 19____

Immediate cause of death Bullet woundand down

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Homicide Date of 3/17/47Where did injury occur? Princess Anne, Md.
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) HomeMeans of Injury Bullet wound Injured at work? no23. SIGNATURE Wm. L. Lough

M. D. or other _____

Address Princess Anne Date signed 3/16/47

RECEIVED

MAR 12 1947

BUREAU

1-35

Dr. Rock

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46



03325

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County Neomig
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
R.O. #3
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED

(For newborn infants give residence of mother)

State MD County Neomig
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. R.O. #3
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Wiggin H. Littleton

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife William M. Littleton

7. Birth date of deceased (mo., day, yr.) May 8th 1901

8. AGE: Years 45 Months 10 Days 5 If less than one day hrs. min.

9. Birthplace R.O. #3 Salisbury, Md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name John W. Parker

13. Birthplace Pittsville Maryland

14. Maiden name Margaret Elizabeth Sturgis

15. Birthplace near Pittsville, Md.

16. Informant Mr. William M. Littleton

Address R.O. #3 Salisbury Md.

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof March 16-47
(month) (day) (year)

Cemetery or crematory Neomig Mem. Park

Location Salisbury Maryland

18. Funeral director Holloman & Co. Walter K. Holloman

Address Salisbury Maryland

19. 3/16/47 20. H. H. Garrison Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 13th 1947 at 2:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 26 1946 to March 12 1947
and that I last saw him alive on March 12 1947

Immediate cause of death Tubercular Pneumonia

Due to Cancer of retroperitoneal gland.

Due to Pathological report of gland, removed at operation, showed cancer.

Other conditions ✓

(Include pregnancy within 3 months of death)

Major findings of operations TBC of lung

Autopsy results ✓ Date of op. 12/28/46

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ✓ Date of March 13, 1947

Where did injury occur? ✓ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ✓ Injured at work?

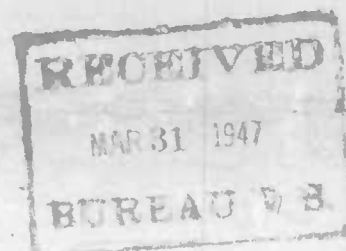
23. SIGNATURE J. H. Webb M. D. or other

Address Salisbury Date signed 3/14/47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

CERTIFICATE OF DEATH

Reg. Dist. No. 03326 333

1. PLACE OF DEATH:

County Wicomico
 City or town Salisbury
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 7 years
 Hospital, institution, or street address where death occurred:
220 Glenn Ave
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Wicomico
 City or town Salisbury
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 220 Glenn Ave
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

3. (b) Social Security Number

Cora W. Mc Cormick
 4. Sex female 5. Color or race white 6.(a) Single, married, widowed, or divorced married
 6.(b) Name of husband or wife Walter B. Mc Cormick
77 6.(c) If alive, give age. 77 years

7. Birth date of deceased (mo., day, yr.) Dec, 11, 1871
 8. AGE: Years 75 Months 3 Days 1 If less than one day hrs. min.

9. Birthplace Galipolis, Gallia Co. Ohio
 (Town, county, and state)

10. Usual occupation At Home

11. Industry or business

12. Name Alexander Willey

13. Birthplace Belford, Ireland

14. Maiden name Mary Nesbitt

15. Birthplace Gallia Co Ohio

16. Informant Mrs. John Fuhn

Address Salisbury, Md.

17. Burial Date thereof 3/14/47
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Parsons Cemetery

Location Salisbury, Md.

18. Funeral director The Hill & Johnson Co.

Address Salisbury, Md.

19. 3/14/47 19 47
 (Date rec'd by registrar) Registrar Robert J. E. Johnson

MEDICAL CERTIFICATION

20. DATE OF DEATH March 12, 1947 at 30P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 9, 1946 to March 12, 1947
 and that I last saw her alive on March 12, 1947

Immediate cause of death Acute Pulmonary Edema DURATION 12 hrs.

Due to Intense sclerotic Heart Disease ?

Due to Arteriosclerosis ?

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert J. E. Johnson

Address Salisbury, Md. M. D. or other 3-14-47
 Date signed

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 31 1947

BUREAU OF S.

2-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (7)

CERTIFICATE OF DEATH



03327

Reg. Dist. No. 339

1. PLACE OF DEATH:

County WicomicoCity or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 hoursHospital, institution, or street address where death occurred:
Peninsula General Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WicomicoCity or town Fruitland
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3.(a) FULL NAME

Harvey C. Mezick

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
<u>male</u>	<u>white</u>	<u>married</u>

6.(b) Name of husband or wife Clevie S. Mezick6.(c) If alive, give age 43 years7. Birth date of deceased (mo., day, yr.) Nov. 7, 1874

8. AGE:	Years	Months	Days	If less than one day
	<u>72</u>	<u>4</u>	<u>5</u>	hrs. min.

9. Birthplace Wicomico Co., Maryland
(Town, county, and state)10. Usual occupation Auctioneer

11. Industry or business

12. Name Isaac L. Mezick13. Birthplace Wicomico Co. Md.14. Maiden name Elizabeth Ann White15. Birthplace Wicomico Co. Md.16. Informant Mrs. Harvey C. MezickAddress Fruitland, Md.17. Burial 3/14/47
(Burial, cremation, or removal Which?) (month) (day) (year)Cemetery or crematory Fruitland CemeteryLocation Fruitland, Md.18. Funeral director The Hill & Johnson Co.Address Salisbury, Md.19. 3/14/47 (Date rec'd by registrar) Registrar Harriet E. Johnson

MEDICAL CERTIFICATION

March 12, 1947 10:30A.

20. DATE OF DEATH March 12, 1947

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

3-12-47 to 3-12-47and that I last saw him alive on 3-12-47

Immediate cause of death

Rupture abdominal aorta;Due to arteriosclerosis.Due to duration unknown.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Ruptured aortaDate of op. 3-12-47

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Harriet E. JohnsonAddress Salisbury, Md.Date signed 3/14/47

RECEIVED

MAR 31 1947

BUREAU V. S.

2-35

RECEIVED

APR 12 1947

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Wanner

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 50

CERTIFICATE OF DEATH

03329

Reg. Dist. No. 3330

1. PLACE OF DEATH:

County Salisbury
 City or town McCombs
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For new born infants give residence of mother)

State Md. County McCombs
 City or town Salisbury
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 512 Mitchell street
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

female White Widow

6. (b) Name of husband or wife

6. (c) If alive, give age

7. Birth date of

deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

Immediate cause of death

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur?

Injured at home, farm, industry, public place (where?)

Means of injury

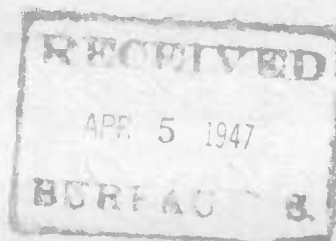
Injured at work?

23. SIGNATURE

Address

M. D. or other

Date signed



2-35-

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 163M

CERTIFICATE OF DEATH

Reg. Dist. No. 3350

1. PLACE OF DEATH:

County... Wicomico
 City or town... Sharptown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 24 years
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED

(For newborn infants give residence of mother)

State... MD County... Wic
 City or town... Sharptown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No...
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Owens, W. Glen

3. (b) Social Security Number

none

4. Sex

M

5. Color of race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Pauline Owens6. (c) If alive, give age... 51 years

7. Birth date of

deceased (mo., day, yr.)

Jan 12 1892

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

5511

9. Birthplace

Sussex Co. Del.

(Town, county, and state)

10. Usual occupation

General Merchant

11. Industry or business

MOTHER FATHER

12. Name

Edward J. Owens

13. Birthplace

Del.

14. Maiden name

Lillian Phillips

15. Birthplace

Del.

16. Informant

Ruby Owens

Address

Dellmar, Del. R.D.

17.

(Burial, cremation, or removal, which?)

Date thereof

3-16-1947
(month) (day) (year)

Cemetery or crematory

Firemans

Location

Sharptown

18. Funeral director

Gravenor Bros

Address

Sharptown

19.

(Date rec'd by registrar)

3-15 47 (Walter) J. Mason
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... 3/12 19... 47 at... unknown

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from...
 and that I last saw... deceased alive on... 3/12/47 at... Sharptown, Del.

Immediate cause of death

Carbon monoxide poisoning

DURATION

supply
that

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

None

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Suicide Date of... 3/12/47Where did injury occur? Sharptown, Wicomico (City of town) (County) (State)Injured at home, farm, industry, public place (where?) woods roadMeans of injury connected with injured at work? No
after 8 inside car

23. SIGNATURE

Dr. Rademacher M.D.

M.D. or other

Address... Sharptown, Del. Date signed... 3/14/47

RECEIVED

MAR 18 1947

BUREAU V S

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03331

Reg. Dist. No. 3330

1. PLACE OF DEATH:

County McComie
 City or town Salisbury
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

R.D. #3 Delmar Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County McComie
 City or town Salisbury
 (If outside city or town limits, write RURAL and give nearest town)

Street No. R.D. #3 Delmar Road
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

William Dow Peck

3. (b) Social Security Number

4. Sex Male 5. Color of race White 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Lillie Slight Peck
 6.(c) If alive, give age 86 years

7. Birth date of deceased (mo., day, yr.) Aug. 8 - 1855

8. AGE: Years 91 Months 7 Days 9 If less than one day
 hrs. min.

9. Birthplace Brooklyn N.Y.
 (City, town, county, and state)

10. Usual occupation None

11. Industry or business

12. Name Ralph Sanford Peck13. Birthplace Gordonsville, N.Y.14. Maiden name Marion Marquisee15. Birthplace Gordonsville N.Y.16. Informant Mr. Lillie S. PeckAddress R.D. #3 Salisbury Maryland17. Burial Date thereof March 19-47

(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Quone Cem.Location Salisbury Maryland18. Funeral director William J. Walter & HollmanAddress Salisbury Md.19. 3/19 19 47 Registrar John H. Harris

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 17 19 47 2300

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from

and that I last saw medically alive on March 17 19 47

Immediate cause of death

Fractured Rt hipDURATION 3/2/47

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations None

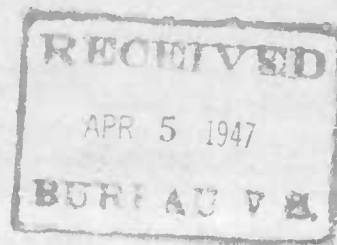
Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 3/2/47Where did injury occur? Quone Cem. (City or town) vicinity (State) MDInjured at home, farm, industry, public place (where?) NoneMeans of injury Fall down steps Injured at work? No23. SIGNATURE John H. Harris M. D. or otherAddress Salisbury Md. Date signed 3/17/47



2-35-

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

03332
3330

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

6. (c) If alive, give age

7. Birth date of

deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

10. Usual occupation

11. Industry or business

MOTHER-FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal, which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Mar 18

19. 47

at 1230 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec

19. 46

to Mar 18

19. 47

and that I last saw him alive on

Mar 18

19. 47

Immediate cause of death

Gummatous Declusum
Second attack.

DURATION

1/2 hr

Due to

Due to

Other conditions

Had surgery Declusum
on Dec 28/46

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

H. S. Kuhlman
Sharptown Md

M. D. as atty

Address

Date signed

3/20/47

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MAR 22 1947

BUREAU

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 937

CERTIFICATE OF DEATH *not in*

03333

Reg. Dist. No. 9330

1. PLACE OF DEATH:

County *Wicomico*
 City or town *Rt #2 Salisbury*
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? *1 yr*
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Maryland* County *Worcester*
 City or town *Berlin R & D.*
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Parker E. Rayne

3. (b) Social Security Number

4. Sex *M* 5. Color or race *W* 6. (a) Single, married, widowed, or divorced *Widowed*6. (b) Name of husband or wife *Martha Hadder Rayne*7. Birth date of deceased (mo., day, yr.) *June 29 1856*8. AGE: Years *89* Months *9* Days *13* If less than one day _____ hrs. _____ min.9. Birthplace *near Pottsville Md.*
(Town, county, and state)10. Usual occupation *Farmer*11. Industry or business *Cassidy*12. Name *Parker E. Rayne Sr*

13. Birthplace

14. Maiden name *Julia*

15. Birthplace

16. Informant *Mrs. Sadie Dennis*Address *Rt #2 Salisbury*17. *Burial* Date thereof *3/14/47*
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory *Riverside*Location *Berlin Md R & D*18. Funeral director *Anna A Burkay*Address *Berlin Md.*19. *3/14/47* (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH *Mar 12 1947* at *11:40A* M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1946 to *Mar 12 1947*and that I last saw him alive on *Mar 10 1947*

Immediate cause of death

*Chromyocarditis*Due to *Chro Prostatitis*

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Manner of injury Injured at work?

23. SIGNATURE

Address *John W. Dennis M.D. Salisbury Md* Date signed *Mar 12*

RECEIVED

APR 7 1947

BUREAU OF

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 178-A

CERTIFICATE OF DEATH

Reg. Dist. No. 3330

1. PLACE OF DEATH:

County... Wisconsin
City or town... 317 Truett St. Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State md. County Wisconsin
City or town... Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 317 Truett St.
(If rural, give LOCATION)
2. (a) If veteran, name war World War II

3. (a) FULL NAME

Elmer Washington Robinson

3. (b) Social Security Number

18-05-8054

4. Sex m 5. Color or race w 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife Elmer A. Robinson

7. Birth date of deceased (mo., day, yr.) Nov. 7, 1907 8. (c) If alive, give age... years

8. AGE: Years 39 Months 3 Days 25 It less than one day... hrs. min.

9. Birthplace Nanticoke, Wisconsin, Md.
(Town, county, and state)

10. Usual occupation Truck Driver

11. Industry or business

12. Name Elmer Robinson, Sr.

13. Birthplace Mardela, Md.

14. Maiden name Ruby Evans

15. Birthplace Nanticoke, Md.

16. Informant Eaton Webster

Address Waterview, Md.

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof 3/9/47
(month) (day) (year)

Cemetery or crematory Cemetery, (Turners)

Location Nanticoke, Md.

18. Funeral director C. G. Messicks

Address Bivalve, Md.

19. 3/9/47 Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 5 19 47 at Salisbury, Md.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from medical and that I saw him alive on 2/28/47

Immediate cause of death Carbon monoxide poisoning

Due to Carbon monoxide poisoning

Due to Carbon monoxide poisoning

Other conditions None

(Include pregnancy within 8 months of death)

Major findings of operations None

Date of op. None

Autopsy results None

PHYSICIAN: Please underwrite the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following:

Accident, suicide, or homicide Accident Date of 3/5/47

Where did injury occur? Salisbury, Wisconsin
(City or town) (County) (State)

Injured at home, farm, industry, public place (where)? Home

Means of injury Gas burning Injured at work? no

asphyxiated

23. SIGNATURE Dr. R. D. Messicks M. D. or other

Address Salisbury, Md. Date signed 3/7/47

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

03334

RECEIVED

MAR 27 1947

BUREAU

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 170-A

CERTIFICATE OF DEATH

03335

Reg. Dist. No. 3930

1. PLACE OF DEATH:

County... Wicomico
City or town... Salisbury, 317 Inset St.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... md. County... Wicomico
City or town... Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 317 Inset St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Elmira Amelia Robinson

3. (b) Social Security Number

213-10-1707

4. Sex F 5. Color or race W 6.(a) Single, married, widowed, or divorced married

6.(b) Name of husband or wife... Elmer Robinson

7. Birth date of deceased (mo., day, yr.) Feb. 6, 1917 6.(c) If alive, give age... years

8. AGE: Years 30 Months 0 Days 24 If less than one day
hrs. min.

9. Birthplace... Waterview, Wicomico, Md.
(Town, county, and state)

10. Usual occupation... Shift Factory Operator

11. Industry or business

12. Name... James E. Webster
13. Birthplace... Waterview, Md.

14. Maiden name... Ella Owen
15. Birthplace... Bivalve, Md.

16. Informant... Elton Webster
Address... Waterview, Md.

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof... 3/9/47
(month) (day) (year)
Cemetery or crematory... Summers Cemetery
Location... Nanticoke, Md.

18. Funeral director... E. E. Messick
Address... Bivalve, Md.

19. (Date recd by registrar) 3/9/47 Registrar W. H. Herring

MEDICAL CERTIFICATION

20. DATE OF DEATH... March 5 1947 at Waterview, Md.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from medical 1947 to 1947 and that I last saw him alive on 2/20/47 Immediate cause of death... Carbon Monoxide poisoning

Due to...
Due to...
Other conditions...
(Include pregnancy within 8 months of death)

Major findings of operations... None Date of op...
Autopsy results... no
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide... Accident Date of 3/5/47
Where did injury occur? Salisbury, Wicomico, Md.
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Home
Means of injury... gas burner asphyxiated Injured at work? no

23. SIGNATURE... W. H. Herring M.D. or other
Address... Salisbury, Md. Date signed... 3/7/47

MARGIN RESERVED FOR BINDING

I

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 27 1947

BUREAU OF

2-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1862

CERTIFICATE OF DEATH

03336

Reg. Dist. No. 399

1. PLACE OF DEATH:

County WicomicoCity or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Penninsula General Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WicomicoCity or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)Street No. 404 Ellen Street
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

George Edward Sample

3. (b) Social Security Number

220-01-7903

4. Sex

Male

5. Color or race

B.

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Catharine Sample

7. Birth date of deceased (mo., day, yr.)

about 1912

6. (c) If alive, give age..... years

8. AGE:

Years about 35

Months

—

Days

—

If less than one day

hrs. min.

9. Birthplace

Accomac, Accomac Co., Va.

(Town, county, and state)

10. Usual occupation

Labourer

11. Industry or business

Same as above

FATHER

MOTHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Location

18. Funeral director

Address

19. Date rec'd by registrar

Date

19. 3/23/47

19. 4/1/47

19. 4/1/47

19. 4/1/47

19. 4/1/47

19. 4/1/47

19. 4/1/47

MEDICAL CERTIFICATION

20. DATE OF DEATH

March 20,19. 47 at 5:50 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw deceased alive on March 20 19. 47

Immediate cause of death

Subarachnoid hemorrhage
consequence of trauma

DURATION

5 days5 days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

none

Date of op.

Autopsy results

none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 3/14/47Where did injury occur? Salisbury accident md

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) NoneMeans of Injury Fall down stairs Injured at work? No

23. SIGNATURE

Dr. R. E. Johnson

M. D. or other

Address

Salisbury, Md.Date signed 3/20/47

RECEIVED

APR 12 1947

BUREAU V 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (832)

CERTIFICATE OF DEATH

03337

Reg. Diat. No. 333

1. PLACE OF DEATH:

County Wicomico
 City or town Salisbury Md. Spring Hill Road
 (If outside city or town limits, write RURAL and give nearest town)
3 Months
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Wicomico
 City or town Salisbury
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Adolphus Lake Seabrease

3. (b) Social Security Number

4. Sex

Male

5. Color of race

WhiteMarried6. (b) Name of husband or wife Alphonse Seabrease6. (c) If alive, give age 68 years7. Birth date of deceased (mo., day, yr.) April. 1870

8. AGE: Years 76 Months 10 Days 26 If less than one day
 hrs. min.

9. Birthplace Mardela Md.
(Town, county, and state)10. Usual occupation Retired Merchant
Hardware Store

11. Industry or business

12. Name Tubman Seabrease13. Birthplace Mardela Md.14. Maiden name Elizabeth Jackson15. Birthplace Mardela Md.16. Informant James L. Seabrease

Address 108 Brooklyn Ave Salisbury Md.

17. Burial Date thereof Mar. 28, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)Wicomico Menorial Park Cemetery

Cemetery or crematory

Location Salisbury Md.18. Funeral director Holloway & Co Per. R. M. ManAddress 520 E. Church St. Salisbury Md.19. 3/28/47 19. 471 Harrison St. Salisbury Md.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 26th, 1947 at 5 a. m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 43 March 25 to 47
 and that I last saw him alive on March 24 1947

Immediate cause of death hypertension of DURATION 3 wksheartarteriosclerosisDue to arteriosclerosisDue to arteriosclerosisOther conditions hypertension withcongestive heart failure 1947

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE _____ M. D. or other _____

Address Salisbury Md Date signed 3/25/47

RECEIVED

APR 12 1947

BUREAU V 8

Dr. Rademaker

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93-1

03338

CERTIFICATE OF DEATH

Reg. Dist. No. 3330

1. PLACE OF DEATH:

County... Wicomico
City or town... Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Pen. Inst. 101stHow long in hospital or institution? 12 Day 12 hour 40 min

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... md County... Wicomico
City or town... Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 415 E. William street
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Mary Caroline Shockley

3. (b) Social Security Number

4. Sex

female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Preston E. Shockley6. (c) If alive, give age. 48 years

7. Birth date of

deceased (mo., day, yr.) Sept. 21 - 1900

8. AGE:

46 Years 5 Months 22 Days If less than one day
hrs. min.

9. Birthplace

Charfield C. Pa.
(Town, county, and state)

10. Usual occupation

Home wife

11. Industry or business

Albert W. Pittman

12. Name

Clarence C. Pa.

13. Birthplace

Eliza Patterson

14. Maiden name

Charfield C. Pa.

15. Birthplace

Mrs. Preston E. Shockley

16. Informant

415 E. William St. Salisbury Md

17. Burial

March 15-47

(Burial, cremation, or removal. Which?)

Hammond Cem.

Cemetery or crematory

Near Mt. Vernon Md. P.O. Salisbury Md.

Location

Hillman & G. Walter R. Hillman

18. Funeral director

Salisbury Md.

Address

3/16/47

19. (Date rec'd by registrar)

H. C. BarrettJohn

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... March 13-47 3459

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb. 1 1947, to March 13 1947and that I last saw him alive on March 13 1947

Immediate cause of death

Pulmonary & Popliteal emboli

Due to

chronic myocarditis

Due to

venous thrombosis both legs

Other conditions

overinjured

(Include pregnancy within 3 months of death)

Major findings of operations

venous thrombosis

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... no

Date of

Where did injury occur?

(City or town) (County) (State)

Injured there, farm, industry, pub'c place (where?)

Means of injury

Injured at work?

23. SIGNATURE

J. A. Rademaker mdAddress... Salisbury MdDate signed... March 14/47

MARGIN RESERVED FOR BINDING

VS A15 9.45.15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



2-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County Wicomico
 City or town Salisbury
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 days
 Hospital, institution, or street address where death occurred:

Pocomoke General Hospital
 How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Worcester
 City or town Pocomoke
 (If outside city or town limits, write RURAL and give nearest town)

Street No. _____
 (If rural, give LOCATION)

2.(a) if veteran, name war. _____

3. (a) FULL NAME

Sturgis Simms

3. (b) Social Security Number

4. Sex Male 5. Color or race C 6.(a) Single, married, widowed, or divorced widowed

6.(b) Name of husband or wife Mary Beauchamp
 6.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) 1875

8. AGE: Years 72 Months _____ Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace Pocomoke, Worcester, Md.
 (Town, county, and state)

10. Usual occupation Day laborer

11. Industry or business _____

12. Name unknown

13. Birthplace _____

14. Maiden name unknown

15. Birthplace _____

16. Informant Grace Sturgis

Address Pocomoke city, Md.

17. Burial Date thereof March 19, 1947
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Halls Hill

Location Pocomoke city Rural

18. Funeral director Margarette H. Watson

Address Pocomoke city, Md.

19. 9/19 47 Worcester John
 (Date read by registrar) (year) (month) (day) (signature) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 17 19 47 at 8:45 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

_____ 19 _____, to _____ 19 _____

and that I last saw him _____ alive on _____ 19 _____

Immediate cause of death _____

DURATION

Renal & hepatic failure 1 day

Due to arteriosclerosis yes

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

_____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

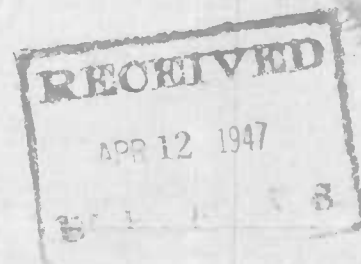
Whom did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE W. H. H. H. M. D. or other _____

Address Salisbury Date signed 3/18/47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 970

CERTIFICATE OF DEATH

Reg. Dist. No. 11

1. PLACE OF DEATH:

County Wicomico
 City or town Delmar
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 40 years
 Hospital, institution, or street address where death occurred:
208 Elizabeth St
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Wicomico
 City or town Delmar
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 208 Elizabeth
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

David Jackson Snowden

3. (b) Social Security Number

716-03-1666

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Adelle Snowden
 7. Birth date of deceased (mo., day, yr.) Dec 5 - 1884 6. (c) If alive, give age 68 years
 8. AGE: Years 62 Months - Days - If less than one day - hrs. - min.

9. Birthplace Kingstree, S.C.
 (Town, county, and state)
 10. Usual occupation Engineer
 11. Industry or business Pen. Railroad Co

FATHER
 12. Name Walter Snowden
 13. Birthplace Kingstree, S.C.
 MOTHER
 14. Maiden name Margaret Singletary
 15. Birthplace Kingstree, S.C.
 16. Informant Wm Adelle Snowden
 Address Delmar, Del.

17. Burial Date thereof 3/23/47
 (Burial, cremation, or removal, which) (month) (day) (year)
 Cemetery or crematorium St Olive Methodist
 Location Delmar, Del.
 18. Funeral director W-S. Marvel Co
 Address Delmar, Del.

19. 3-22 19 47 Harry E. Hudson
 (Date rec'd by registrar) Registrar

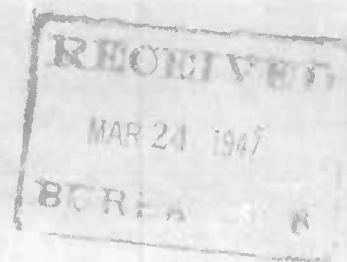
MEDICAL CERTIFICATION

20. DATE OF DEATH March 20 19 47 at 2:50 A.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 18, 46 to March 20, 47
 and that I last saw him alive on March 18 19 47

Immediate cause of death Coronary Thrombosis DURATION 10 min.
Coronary sclerosis 6 months
 Due to.....
 Due to.....
 Other conditions Essential Hypertension?
 (Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.
 Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
 Accident, suicide, or homicide..... Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?
 23. SIGNATURE H. V. Lohler, M.D. M. D. or other 3-20-47
 Address Delmar, Md. Date signed



1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. **3330**

*03340

1. PLACE OF DEATH:

County WicomicoCity or town Salisbury, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Since 8/28/46

Hospital, institution, or street address where death occurred:

E. S. Tb. Sanatorium, Salisbury, Md.How long in hospital or institution? Since 8/28/46

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County SomersetCity or town Westover

(If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

2. (a) If veteran, name war No ✓

3. (a) FULL NAME

Somers, Sallie E.

3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6. (a) Single, married, or divorced

Married6. (b) Name of husband or wife Charles Henry Somers6. (c) If alive, give age 76 years7. Birth date of deceased (mo., day, yr.) Feb. 28, 18738. AGE: Years 74 Months 9 Days 7 If less than one day _____ hrs. _____ min.9. Birthplace Fairmount, Md.
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name Wm. Richard Tuss Tull13. Birthplace Maryland14. Maiden name -----McGraw15. Birthplace Maryland16. Informant self

Address

17. Burial Date thereof 3-10-1947
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory EpiscopalLocation Princess Anne Md.18. Funeral director Charles DaskiellAddress Princess Anne Md.19. 3/8 H. H. Haggard, Jr. Registrar
(Date rec'd by registrar) (Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 7 19 47 at 12:45^a M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 28 19 47 to March 7 19 47 and that I last saw him er alive on March 6 19 47Immediate cause of death Interosseal - HypertensionCardio-vascular disease

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

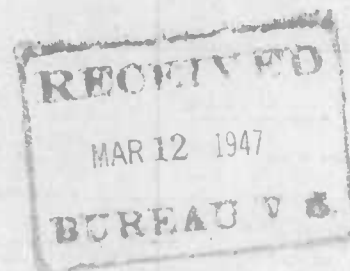
Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Paul M. D. or otherNow Hill, Md. Address _____ Date signed 3/7/47



1-38

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 159

CERTIFICATE OF DEATH

Reg. Diat. No. 3730

1. PLACE OF DEATH:

County Wicomico
City or town Salisbury, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Peninsula General HospitalHow long in hospital or institution? 13 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD. County Somerset
City or town Princess Anne
(If outside city or town limits, write RURAL and give nearest town)
Street No. 316 Bedford Ave
(If rural, give LOCATION)2. (a) If veteran, name war ✓

3. (a) FULL NAME

Spence, Baby Boy

3. (b) Social Security Number

4. Sex male 5. Color or race colored 6. (a) Single, married, widowed, or divorced premature

B. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) March 4, 1947 - 6³⁰ AM8. AGE: Years Months Days If less than one day 13 hrs. min.9. Birthplace Princess Anne, Maryland
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name Roland Spence13. Birthplace Somerset County14. Maiden name Betty E. Spence15. Birthplace Somerset County16. Informant Roland SpenceAddress Princess Anne, Md.17. Burial, cremation, or removal-Which? Burial Date thereof 3/6/47
(month) (day) (year)Cemetery or crematory John WesleyLocation Princess Anne, Md.18. Funeral director William H. James Jr.Address Princess Anne, Md.19. 3/6/47 (Date read by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 4 19 47, at 9²⁵ P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4 March 19 47 to 4 March 19 47 and that I last saw him alive on 4 March 19 47Immediate cause of death Prematurity DURATION 15 hours

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE William H. James Jr. M. D. or otherAddress Salisbury, Maryland Date signed 5 March 1947

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAR 11 1947
BUREAU OF S.

2-35-

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age in full. Write the cause of death clearly and legibly. is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 100

CERTIFICATE OF DEATH

Reg. Dist. No. 03342 335

1. PLACE OF DEATH:

County..... Wicomico
 City or town..... Salisbury
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 11 days
 Hospital, institution, or street address where death occurred:
Peninsula General Hospital
 How long in hospital or institution?..... 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State..... Maryland County..... Wicomico
 City or town..... Salisbury
 (If outside city or town limits, write RURAL and give nearest town)
 Street No...... R.D. 2 Johnson Road
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Robert W. Staton

3. (b) Social Security Number

4. Sex..... male 5. Color or race..... white 6.(a) Single, married, widowed, or divorced..... widowed
 6.(b) Name of husband or wife..... Ilda B. Staton
 7. Birth date of deceased (mo., day, yr.)..... Sept. 11, 1856 6.(c) If alive, give age..... years
 8. AGE: Years..... 90 Months..... 6 Days..... 3 If less than one day..... hrs. min.

9. Birthplace..... Wicomico Co., Md.
 (Town, county, and state)
 10. Usual occupation..... Retired
 11. Industry or business..... Hotel Operator
 12. Name..... Thomas W. Staton
 13. Birthplace..... Wicomico Co., Md.
 14. Maiden name..... Charlotte E. Disharoon
 15. Birthplace..... Wicomico Co., Md.
 16. Informant..... Mrs. Agnes E. Malone
 Address..... Salisbury, Md.

17. Burial..... Burial Date thereof..... 3/17/47
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory..... Parsons Cemetery
 Location..... Salisbury, Md.
 18. Funeral director..... The Hill & Johnson Co.
 Address..... Salisbury, Md.

19. 3/17 19 47 Harriet E. Johnson
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

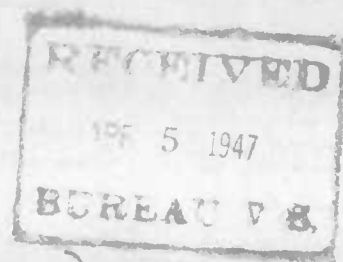
20. DATE OF DEATH..... March, 14, 1947 19 47 10A.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from mid 1947 to Mar 14 1947
 and that I last saw him alive on Mar 13 1947
 Immediate cause of death..... Solar Pneumonia DURATION 2 wks
 Due to..... Chronic valvular heart dis 2
 Due to.....
 Other conditions.....
 (Include pregnancy within 8 months of death)

Major findings of operations.....
 Date of op.....
 Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?..... (City or town) (County) (State)
 Occurred at home, farm, industry, public place (where?)
 Means of injury..... Injured at work?

23. SIGNATURE..... Harriet E. Johnson M. D. or other
 Address..... Salisbury Date signed..... APR 15



2-35-

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(93d)

CERTIFICATE OF DEATH

Reg. Dist. No. 3390

1. PLACE OF DEATH:

County Wicomico
 City or town Quantico
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 60 years
 Hospital, institution, or street address where death occurred:
Quantico R. D. I
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Wicomico
 City or town Quantico Rural I
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3.(a) FULL NAME

Annie B. Taylor

3.(b) Social Security Number

4. Sex female 5. Color or race white 6.(a) Single, married, widowed, or divorced widowed
 6.(b) Name of husband or wife Charles I. Taylor
 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) Jan. 3, 1864.
 8. AGE: Years 83 Months 2 Days 6 If less than one day _____ hrs. _____ min.

9. Birthplace Quantico, Md. Wicomico Co.
 (Town, county, and state)

10. Usual occupation At Home

11. Industry or business

12. Name Columbus Messick
 13. Birthplace Wicomico Co. Md.
 14. Maiden name Mareitta Venables
 15. Birthplace Wicomico Co. Md.

16. Informant Mrs. WM. B. Woolford
 Address Quantico, Md. R. D. I

17. Burial Date thereof 3/11/47
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Quantico Cemetery
 Location Quantico, Md.

18. Funeral director The Hill & Johnson Co.
 Address Salisbury, Md.

19. 3/11/47 19 H. T. Haggie Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 9, 1947 19 47 2 45P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Dec 30, 1946 19 46 to March 9 19 47
 and that I last saw him alive on March 8th 19 47

Immediate cause of death Respiratory failure. DURATION 2 days

Due to Cerebral Hemorrhage 7 days.

Due to Hypertension 3

Other conditions arteriosclerotic
cardio vascular disease. 2
 (Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work?

23. SIGNATURE Robert Gore, MD M. D. or other _____
 Address 3021 N. Division St. Date signed 3-11-47
Salisbury, Md

RECEIVED

MAR 27 1947

BUREAU

2-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH



03345

Reg. Dist. No. 8390

1. PLACE OF DEATH:

County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Penninsula General Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County WorcesterCity or town Ocean City
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2. (a) If veteran, name war _____

3. (b) Social Security Number

3. (a) FULL NAME

Taylor Thomas Lee

4. Sex

male

5. Color or race

C

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife _____

6. (c) If alive, give age _____ years

7. Birth date of

deceased (mo., day, yr.)

1885

8. AGE:

About 62

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Georgia
(Town, county, and state)

10. Usual occupation

Laborer.

11. Industry or business

FATHER

12. Name

unknown

13. Birthplace

MOTHER

14. Maiden name

unknown

15. Birthplace

16. Informant

Mr Thomas Elliott

Address

Ocean City md

17. (Burial, cremation, or removal, Which?)

Burial

Date thereof

3/13/47
(month) (day) (year)

Cemetery or crematory

St. Pauls

Location

Berlin md

18. Funeral director

Anna D. Burban

Address

Berlin md

19.

3/13/47
(Date rec'd by registrar)1947Harriet E. JohnsonDeputy

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

March 11 1947 at 12:20 P.M.

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from

Mar. 5 1947 to Mar. 11 1947and that I last saw him alive on March 11 1947

Immediate cause of death

Pulmonary Tuberculosis Duration
Bilateral far advanced 4 mos.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work

23. SIGNATURE

David Gilmore M.D.

M.D. or other

Address

301 N. Division

Date signed

Mar 11, 1947Salisbury, Md.

RECEIVED
APR 7 1947
BUREAU V B

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *MO*

CERTIFICATE OF DEATH

Reg. Dist. No. *339*

1. PLACE OF DEATH:

County *Wicomico*
City or town *Salisbury, Maryland*
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Peninsula General Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Maryland* County *Worcester*City or town *Newark*
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2. (a) If veteran, name war _____

3. (a) FULL NAME

Taylor, Baby Boy

3. (b) Social Security Number

4. Sex *Male* 5. Color or race *White* 6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife _____

7. Birth date of

deceased (mo., day, yr.)

6. (c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

hrs. *30* min.9. Birthplace *Salisbury, Md.*
(Town, county, and state)

10. Usual occupation _____

11. Industry or business _____

FATHER 12. Name *Taylor Carl Francis*13. Birthplace *Newark, Maryland*MOTHER 14. Maiden name *Hayman Agnes*15. Birthplace *Willards, Maryland*

16. Informant _____

Address _____

17. ☒ (Burial, cremation, or removal. Which?)

Date thereof

March 22, 1947
(month) (day) (year)Cemetery or crematory *Peninsula General Hospital*

Location

18. Funeral director _____

Address *Salisbury, Md.*19. *3/25/47* 19. *3/25/47*
(Date rec'd by registrar)*Barclay G. Johnson*
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *March 22, 1947* at *4:00* P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19_____, to _____ 19_____.
and that I last saw him _____ alive on _____ 19_____.Immediate cause of death *Perinatal*

DURATION

*1 hour*Due to *Early labor*Due to *Placenta Previa*
(mother)

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injury at home, farm, industry, public place (where?) _____

Means of injury _____

Injured at work? _____

23. SIGNATURE *Hermona Ruben*

M. D. or other

Address _____ Date signed _____

MARGIN RESERVED FOR BINDING

VS A15 9.45.15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 12 1947

BUREAU V 6

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 32A

CERTIFICATE OF DEATH

03346

Reg. Dist. No. 3270

1. PLACE OF DEATH:

County Wicomico
City or town Ches
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
.....
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State MD County Wicomico
City or town Ches
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Miss Cora Timmons

3. (b) Social Security Number

4. Sex F 5. Color or race W. 6.(a) Single, married, widowed, or divorced Widow

6.(b) Name of husband or wife George Timmons

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 7, 1875

8. AGE: Years 69 Months 9 Days 29 If less than one day hrs. min.

9. Birthplace Ches Wicomico, Md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name John J. Hayward

13. Birthplace Bundel

14. Maiden name Sarah W. Timmons

15. Birthplace St Marys B. Md.

16. Informant Robert Timmons

Address Ches Md.

17. Burial Date thereof 3/8/47
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Bivalve Md.

Location Bundel, Maryland

18. Funeral director Dr. J. L. M. Smith

Address Ches Md.

19. Mar 8 19 47 R. H. Walcott Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/6/47 19..... at 2:45 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-13-47 19..... to 3-4-47 19.....

and that I last saw him alive on 3-4-47 19.....

Immediate cause of death Respiratory failure

Due to Cerebral hemorrhage

Due to Hypertension

Other conditions Arteriosclerosis

(Include pregnancy within 8 months of death)

Major findings of operations..... Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

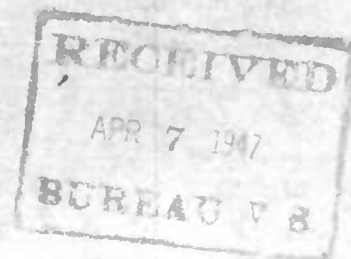
23. SIGNATURE Robert Timmons M. D. or other

Address Salisbury, Md. Date signed 3-10-47

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 197-01

CERTIFICATE OF DEATH

Reg. Dist. No. 333

03347

1. PLACE OF DEATH:

County Wicomico
 City or town Salisbury Md.
 (If outside city or town limits, write RURAL and give nearest town)
Peninsula General Hospital

How long in above place of death?

Hospital, institution, or street address where death occurred:

3 WeeksHow long in hospital or institution? 3 Weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Wicomico
 City or town Salisbury
 (If outside city or town limits, write RURAL and give nearest town)
107 W. Vine St.
 Street No. _____
 (If rural, give LOCATION)

2. (a) If veteran, name war _____

3. (a) FULL NAME

William Prettyman Truitt

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Alice May Truitt6. (c) If alive, give age 69 years7. Birth date of deceased (mo., day, yr.) Feb. 13th 1874

8. AGE: 73 Years 1 Months 18 Days hrs. min.

9. Birthplace Delmar Md. R.F.D.

(Town, county, and state)

10. Usual occupation Freight and Hauling With Truck

11. Industry or business

12. Name Benj. Truitt13. Birthplace Near Delmar Md.14. Maiden name Ellen Palmer15. Birthplace Near Delmar Md.16. Informant Mrs. Alice May Truitt107 W. Vine St. Salisbury Md.

Address

17. Burial Date thereof April. 1. 1947
 (Burial, cremation, or removal, which?) (month) (day) (year)
Parsons Cemetery

Cemetery or crematory

Location Salisbury Maryland18. Funeral director Holloway & Co. Per *Phyllis Holloway*Address 520 E. Church St. Salisbury Md.19. (Date rec'd by registrar) 4/1119. H. T. Barrington

Registrar

MEDICAL CERTIFICATION

March 30th. 47 6.27 A.20. DATE OF DEATH 19 47, at 6.27 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1/13 1947, to 5/30 1947and that I last saw him alive on 5/30 1947

Immediate cause of death

Myocardial Infarction

DURATION

1 hr.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op. 5/20/47

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ✓ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury

Injured at work?

23. SIGNATURE

Address Salisbury Date signed 3/31/47

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APR 12 1947

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 8320

CERTIFICATE OF DEATH

Reg. Dist. No.

03348

3370

1. PLACE OF DEATH:

County... WicomicoCity or town... Tyaskin
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Lifetime

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

William Wainwright

4. Sex

m

5. Color or race

col.

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

June 9, 1891

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

5694

.....hrs.

.....min.

9. Birthplace

Tyaskin, Wicomico, Md.
(Town, county, and state)

10. Usual occupation

General Laborer

11. Industry or business

MOTHER FATHER

12. Name

Levin Wainwright

13. Birthplace

Tyaskin, Md.

14. Maiden name

Georgiana Gates

15. Birthplace

Tyaskin, Md.

16. Informant

Mamie Gates Polk

Address

Tyaskin, Md.

17.

Burial

Date thereof

3/16/47

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

John Wesley Church Cem.

Location

Tyaskin, Md.

18. Funeral director

E. E. Messick

Address

Burialve, Md.

19.

March 16, 1947

19.

Robert J. Messick

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

md.

County

Wicomico

City or town

Tyaskin

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

217-03-1613

MEDICAL CERTIFICATION

20. DATE OF DEATH

March 1419 47at 6:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

February 3 19 47 to March 13 19 47and that I last saw him live on March 13, 1947

Immediate cause of death

Respiratory Failure

DURATION

3 hrs.

Due to

Cerebral hemorrhage2

Due to

Arteriosclerosis2

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Robert J. Messick

M. D. or other

Address

Tyaskin, Md.

Date signed

3-15-47

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APR 7 1947
BUREAU V.B.

2-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 17

CERTIFICATE OF DEATH

Reg. Dist. No. 3330

1. PLACE OF DEATH

County McComickCity or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 yearsHospital, institution, or street address where death occurred 415 Davis St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County McComickCity or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)Street No. 415 Davis St
(If rural, give LOCATION)

2(a) If veteran, name war

3. (a) FULL NAME

Georgianna Walker

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widow6. (b) Name of husband or wife Spencer Walker6. (c) If alive, give age Dead years7. Birth date of deceased (mo., day, yr.) Nov. 20 - 18588. AGE: Years 88 Months 3 Days 9 If less than one day hrs. min.9. Birthplace Mandela Md.
(Town, county and state)10. Usual occupation at Home

11. Industry or business

12. Name Mathias Bailey13. Birthplace Mandela Md.14. Maiden name Mary Brackley15. Birthplace Mandela Md.16. Informant Mrs. Bernice MasonAddress 7. Viv. St. Salisbury Md.17. Buried Date thereof Mar. 14 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Mandela Cem.Location Mandela Maryland18. Funeral director William & C. Waller & Co.Address Salisbury Maryland19. 3/4/47 H. H. Robert Johnson
(Date rec'd by registrar) (Signature) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 14 1947 19 47 at 11:48 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 18 19 47 to March 1 19 47and that I last saw him alive on March 1 19 47Immediate cause of death Broncho pneumonia DURATION 2 daysDue to Senility

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Signature Robert Gore MD M. D. or otherAddress Salisbury Md Date signed 3-4-47

RECEIVED

MAR 11 1947

BUREAU

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (55-2)

CERTIFICATE OF DEATH

03350

Reg. Dist. No. 3990

1. PLACE OF DEATH:

County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 1/2 years
Hospital, institution, or street address where death occurred:
John B. Parsons Home
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. John B. Parsons Home
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Mary B. Ward

3. (b) Social Security Number

4. Sex 5. Color or race 8.(a) Single, married, widowed, or divorced

female white widowed

6.(b) Name of husband or wife John H. Ward

6.(c) If alive, give age. years

7. Birth date of deceased (mo., day, yr.) May 25, 1867

8. AGE: Years Months Days If less than one day
79 9 15 hrs. min.

9. Birthplace Chrisfield, Somerset Co Md.
(Town, county, and state)

10. Usual occupation none

11. Industry or business

FATHER 12. Name W. H. Dize

13. Birthplace Somerset Co. Md.

MOTHER 14. Maiden name Mary E. Coulburn

15. Birthplace Somerset Co. Md.

16. Informant John B. Parsons Home
Address Salisbury, Md.

17. Burial Date thereof 3/14/ 47
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Crisfield Cemetery
Crisfield, Md.
Location

18. Funeral director The Hill & Johnson Co.
Address Salisbury, Md.

19. 3/14/ 47 Harriet L. Johnson Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH March 11, 1947 430A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 4, 1946 to March 11, 1947 and that I last saw her alive on March 10, 1947

Immediate cause of death Respiratory failure DURATION

Due to Chronic cholelithiasis 6 mo.

Due to (Neoplasm?)

Other conditions Abdominal cancer. Anatomical location not diagnosed. suga.
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert R. Starn M. D.

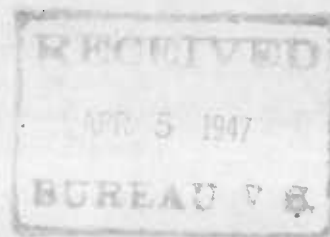
Address Salisbury Date signed 3-14-47

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



2-35

03351

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County *Wicomico*
 City or town *Near Pocomoke*
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *Life time*

Hospital, institution, or street address where death occurred:

P.O. #2 Pittsville Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For neighbors, give residence of mother)

State *Md.* County *Wicomico*
 City or town *Near Pocomoke*
 (If outside city or town limits, write RURAL and give nearest town)

Street No. *P.O. #2 Pittsville Md.*
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

John Hiram Kett

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Mary E. Kett.

7. Birth date of

deceased (mo., day, yr.)

*Oct. 22nd 1862*6. (c) It alive, give age *78* years

8. AGE:

Years

Months

Days

*84**4**23*

It less than one day

hrs. min.

9. Birthplace

Whitton Maryland

10. Usual occupation

Farmers

11. Industry or business

Retired

FATHER

12. Name

Minos Kett

13. Birthplace

Near Whitton Maryland

MOTHER

14. Maiden name

Hettie Elizabeth Bradford

15. Birthplace

Near Millard Maryland

16. Informant

Mr. Dennis S. Kett

Address

P.O. #2 Pittsville Maryland

17. Burial

Mar. 18-47

(Burial, cremation, or removal, Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Dennis Farm Co

Location

Near Pocomoke Md.

18. Funeral director

Holloman & G. Walter K. Holloman

Address

Salisbury Md.

19.

(Date rec'd by registrar)

*3/18/47**H. H. Bassett**Local*

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

March 15th 1947

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

August 1936

and that I last saw him alive on

3-15-47

Immediate cause of death

Myocarditis (chronic)

DURATION

Due to

Due to

Other conditions

Hypertension

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underlie the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Frank R. Lewis M.D.

M. D. or other

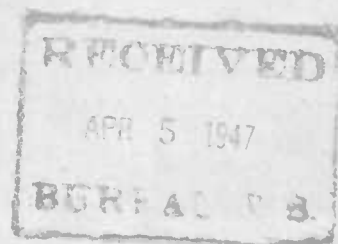
Address

*Wellsboro Maryland*Date signed *3-17-47*

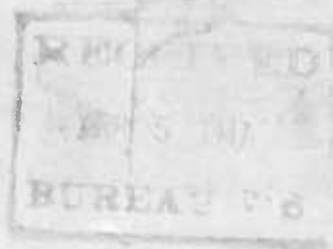
MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



2-35



2-38-